State of Indiana

Addendum to BIP Work Plan

First submission, due January 29, 2013

Updated submission, due March 7, 2013

Updated re-submission, due by April 5, 2013

April 15, 2013

2.1 DESIGN SYSTEM

C. NWD/SEP Agency Partners and Roles

The Office of Medicaid Policy and Planning (OMPP) is the Single State Agency for Indiana's Medicaid program. As such, OMPP will ultimately hold responsibility for oversight over BIP in Indiana and work with CMS to ensure that the commitments made in this application are honored through the term of the program. OMPP has elected to designate the Division of Disability and Rehabilitative Services (DDRS) as the administrative lead for the BIP due to the role the Division plays, today, in administering Long Term Support Services (LTSS). OMPP and DDRS have an existing Memorandum of Understanding (MOU) which will be amended to include the roles and responsibilities enumerated throughout this application.

Indiana is one of 54 states and territories funded by the Administration on Aging (AoA) and CMS to develop an Aging and Disability Resource Center (ADRC) program that streamlines access to long-term care information and community-based services. The goals of Indiana's ADRC system are to streamline access to LTSS information and eligibility for services to help redirect long-term care from institutions to the community. In Indiana, the ADRC system operates statewide with all sixteen Area Agencies on Aging (AAAs) contracted as ADRCs.

Indiana's approach to the Single Entry Point (SEP) system is to assure that individuals seeking assistance from historical and traditional entry points either receive the same information from those traditional entry points or are easily connected with the ADRC. Current Division contracts require formal partnerships between the traditional entry points, such as the Centers for Independent Living, and designated ADRC sites to assure that information is standardized and appropriate referrals are made within the system. As the SEP expands to include populations beyond the aged and physically disabled, relationships with additional traditional entry points, such as Community Mental Health Centers (CMHCs), will also need to be developed. These relationships should not be difficult to establish, as the CMHCs currently act as the SEP for most individuals seeking mental health and substance abuse treatment.

The State's current efforts to co-locate other agencies within the ADRCs will have a significant role in creating a true No Wrong Door/Single Entry Point (NWD/SEP) system for all persons with LTSS needs. The pilot project will bring staff from the Bureau for Developmental Disability Services (BDDS) and the Division of Family Resources (DFR) into the ADRCs to perform their respective eligibility functions. While these staff will continue to be responsible for the functions their Divisions perform, all staff within the ADRC will receive training to ensure that they can assist and/or properly refer individuals with all needs to the appropriate services.

Future steps to integrate the LTSS system include bringing the tradition entry point for behavioral health services into the SEP. Indiana will address this effort as a second phase of the pilot. This will allow the State to assess current entry points into the behavioral health system and determine how to minimize or eliminate any existing conflict of interest. The current entry points for behavioral health, the CMHCs, have experience serving older adults and, consequently, existing relationships with the ADRCs. For many years, the Division of Mental Health and Addiction has required CMHCs to provide services for older adults. Specifically, CMHCs are required to have a plan on how they intend to serve older adults, to designate a contact person for older adult services, and to complete the federally mandated PASRR/MI Level II reviews. In addition to building upon current practice, the State will be able to gain valuable experience through the co-location pilot and work to identify best practices that will ease the transition of future populations.

In addition to physical locations, LTSS users will have access to a website which will contain LTSS information and a self-evaluation of needs. The website will be integrated with a 1-800 number and other Medicaid program information. This integration will ensure that anyone seeking LTSS can review on online directory of services, as well as access a 1-800 number that will allow them to begin the eligibility determination and enrollment process. In addition to the website, all NWD/SEP agencies and partners will have access to the State's planned integrated data system (IDS). This system will provide authorized users access to a single source for all LTSS data, which will further integrate the system ultimately creating a Single Entry Point system with No Wrong Door.

D. NWD/SEP Person Flow

Individuals with LTSS needs will be able to initially seek information about the available service array through either the website, over the phone, or in person at the SEP. Regardless of what door an individual enters, the Medicaid information provided to them will be the same.

An individual accessing the website will have the opportunity to respond to a series of questions which constitute a Level I screen. While they have yet to be developed entirely, the Level I questions may be cultivated from an existing set of questions posed by ADRC sites to consumers upon intake, or by other FSSA Agencies who work with similar populations. The same individual who calls the 1-800 number or presents at a physical SEP location will also have the opportunity to respond to the same series of questions with the assistance of a staff person who will input the information into the website or directly into IDS. Following completion of these questions, if it appears an individual may be eligible, he/she will be referred to appropriate services. If the individual indicates he/she would like to pursue application for any of these services, a referral will be made by the system to the appropriate agency through an automated process, while there may be some instances in which referral by phone or appointment may be required.

The applicant will next be contacted by a staff person from the appropriate BIP partnering agency (Division of Aging, Division of Disability and Rehabilitative Services, or Division of Mental Health and Addiction) to complete the Level II functional assessment. An appointment will be made to complete this additional level of assessment to determine whether the applicant meets the functional criteria for receipt of LTSS. The staff person will be able to use IDS to access the data previously provided by the applicant through the screening process and build upon it to complete the assessment.

In addition to the functional assessment during this appointment, agency staff will be able to assist applicants with the completion of the Medicaid financial eligibility application at ADRCs that have been integrated with DFR staff through the co-location process. This will be the most significant change impacting the person flow within the NWD/SEP system. As of today, waiver application and Medicaid financial eligibility are not completed together, requiring applicants to present at multiple locations and work with multiple staff to complete the two processes. Under the new system, the process will appear seamless to the applicant despite the fact that the functional eligibility data and financial eligibility data will be input and stored in two separate IT systems and approved through separate administering entities.

Once function eligibility and Medicaid financial eligibility are approved, a case manager will contact the newly eligible waiver enrollee to begin the person-centered process of creating a care plan and choosing a provider(s). Once the care plan is approved, services may begin. If there are no slots available on the waiver of application, the applicant will be placed on a waitlist. Once funding becomes available for that waiver slot, the individual will be contacted and service planning will begin.

See Appendix C of Indiana's application for work flows documenting the assessment and eligibility process.

E. NWD/SEP Data Flow

Indiana has been in the process of implementing a new waiver and LTSS case management system (ICMS), which was slated to replace existing systems (INsite/DART/IRIS) in the spring of 2013. However, due to the vendor's exit of the process, the State has had to reconvene and decide a different method by which to develop such a system. Indiana is moving forward with creating a new information data system (IDS), which would link Divisions, providers, and consumers to the extent necessary to ensure LTTS eligibility and assessment processes could exist using broadly accessible databases housing a Core Data Set. The requirements for this new system include a web-based database which will allow for multiple user access including the Indiana Family and Social Services Agency (FSSA), its partner agencies, providers, Medicaid members and the general public. Implementation of this system will move the State toward improving accessibility to data required for determining LTSS eligibility and authorizing services. This single system of record will allow for a more streamlined data flow than exists under current processes.

The IDS system requirements include a Level I screening module which will ask general questions of the applicant to determine their LTSS needs. These data points will be entered through the publically accessible website and stored in the IDS system. Should the applicant choose to make application for services, the system will prompt an internal referral to the most appropriate FSSA Division(s) based on the data provided by the applicant. As a result of this internal system trigger, the FSSA Division staff will review the information obtained through the Level I screening process and contact the applicant to schedule a follow-up appointment.

During the follow-up appointment, the Division staff will access the applicant's data record, containing the Level I screening responses. Utilizing the appropriate population specific assessment module, the staff person will perform a Level II functional ability assessment. Once all required information has been gathered and input into the system, a determination will be made as to whether the individual is eligible for services. Determination of eligibility is dependent upon the program of application. In some programs, the determination may be auto-generated by IDS utilizing a built-in assessment algorithm; for others, state staff may be required to review the gathered data and make a manual determination based on standardized criteria. All functional eligibility determinations will be stored in IDS as the system of record. This information will, therefore, be accessible by all authorized SEP staff.

As the State continues to expand the co-location pilot to additional ADRC offices, applicants residing in those localities will be able to simultaneously make application for Medicaid with completion of the Level II assessment. Functionally, the financial data will be input and stored in a separate system from IDS. While links do exist between the two systems and some data is shared, they are not fully integrated. Information gathered online about an individual can be captured in one location on the web, which will be available for viewing by NWD/SEP agencies, DFR staff, and the appropriate Division through services will be rendered. The determination for waiver services and Medicaid eligibility will also remain distinct as separate Divisions with FSSA administer and authorize each of the processes.

F. Potential Automation of Initial Assessment

As discussed above, Indiana is pursuing the implementation of a new information data system, IDS, in the spring of 2013. IDS will allow for enhanced data gathering, access, and sharing, including automation of the initial assessment. Whether online, over the phone, or at an SEP location, applicants will be able to complete the Level I screening module through the NWD/SEP website. Individuals will be

asked to respond to a series of general questions regarding their functional and financial status. Based on their responses, the website will generate a list of Medicaid and non-Medicaid services for which the individual may be eligible.

Automating the initial assessment process will allow website users to access standardized programmatic LTSS information specific to their needs, in real time. This creates greater transparency for the user, as well as increased efficiencies for the State. Users will be able to educate themselves about information regarding the various community LTSS options that meet their personalized needs. Should they require additional information, they will be able to contact the state using the 1-800number, through which they will be able to speak directly with agency staff and schedule a meeting regarding the functional assessment process, should they choose.

IDS will capture the information entered by the individual for purposes of the initial assessment and store it for future use. Should the individual choose to pursue application for a specific program, this information will be accessed by the appropriate FSSA Division and utilized, along with additional information gathered, to perform the Level II functional assessment.

G. Potential Automation of CSA

The State has envisioned IDS as a web-based database to maximize accessibility for a broad user group. As is discussed further in section H of this application, the State will not be pursuing a single standardized assessment tool at this time. Rather, Indiana has chosen to continue to use the population specific, time tested assessment tools current in use.

The web-based tool has been designed to allow users real time access to functional assessment data. However, given operational barriers/challenges, the reality is that, in many cases, data will not be entered into the system in real time. Some of the functional assessments used by the State were intentionally designed to be completed with the applicant by engaging in an informal dialogue rather than a guided question and answer session. Given the personal nature of some of the required data points, Indiana found that certain populations are more inclined to be open to discussing their functional limitations if done in a more conversational format. As such, these conversations do not lend themselves to the case manager/staff person sitting behind a laptop or computer entering data. Often, the data is entered into the system at a later date and/or time with the use of notes taken by the staff person. In addition, supplying all of the field staff with computers or other electronic means of recording assessment data in real time is cost prohibitive given the limited resources of the State.

The State recognizes the value of automation and has designed the new system to be capable of capturing data in real time. However, given current challenges, this function will not be universally mandated.

H. Incorporation of a CSA in the Eligibility Determination Process

Indiana does not currently utilize a single Core Standardized Assessment (CSA) for LTSS. The assessment tools used today are population specific and have been developed over time to meet the needs of the individual LTSS program criteria.

Indiana has considered the BIP recommendation of creating a single CSA for all LTSS populations. At this time, it has been determined that Indiana will continue to utilize its current assessment tools and work toward ensuring that all necessary data elements are stored, therein, as well as captured and stored within the single information data system, IDS.

The new information data system will have the capability of housing and operating under a single CSA, should the State choose to move in that direction at a future date. The major challenge to the State would be identifying a single tool that adequately captures the various program functional eligibility criteria, while maintaining the reliability and validity that exists today across the current tools. At this time, the State does not have the resources needed (i.e., clinical, financial, or operational) to engage in this significant effort.

Indiana believes its current assessment tools have been successful in meeting the needs of its programs and best serving each individual population seeking services. Utilizing the existing, time-tested assessments will allow the State to focus on streamlining other aspects of the LTSS system, which have a greater impact on the consumer's overall experience.

3.2 Identify the NWD/SEPs

J. Location of SEP Agencies

Indiana proposes to use the statewide ADRC system as the SEP for BIP. Today, the ADRCs are the access points for aged and physically disabled individuals needing LTSS services. The State is divided into 16 Areas, each of which is overseen by a contracted ADRC. The State has set-up the system to ensure that all Hoosiers live within the service area of an ADRC. Per contracts, the ADRCs must meet State access standards and ADA accessibility standards. One such standard requires that ADRC staff conduct functional assessments with applicants in their homes, thereby eliminating the need for older adults and individuals with physical disabilities to travel.

As the State engages in the co-location pilot, these physical locations will eventually house staff capable of assisting LTSS applicants with all their Medicaid eligibility needs. Current plans for the pilot include adding BDDS and DFR staff to Area 8 which covers central Indiana, specifically, Marion, Boone, Hamilton, Hancock, Shelby, Johnson, Morgan and Hendricks counties. As the State gains experience with the pilot, additional Areas will be converted to co-located ADRCs. The final phase of the co-location process will identify best practices for incorporating into the SEPs staff from agencies charged with assisting individuals with serious mental illness.

The State will be able to sustain the co-location and existence of NWD/SEPs by decreasing the physical footprint that FSSA has imprinted the state. In the Division of Disability and Rehabilitative Services, efforts have been made to lessen the physical space out of which two of its bureaus are located. The Division has sixteen (16) Vocational Rehabilitation (VR) offices through its Bureau of Rehabilitative Services (BRS), and eight (8) offices (nine locations – one district has two offices) through its Bureau of Developmental Disability Services (BDDS). For the past several years, these 24 locations were each separated, or only a few coexisted in the same building.

In an effort to alleviate duplication of cost associated with leased space, some of these locations – especially those that were already in close proximity – were combined. Also, projects such as scanning paper files that were housed in some of these spaces were scanned and placed into electronic storage, demonstrating a lesser need for large office space. The combination of many of our offices with ADRCs will further reduce our costs by reducing space costs and certain equipment duplication, thereby making sustainability of co-location of NWD/SEPs feasible. Further, over time we expect cross training to allow for staff reductions in intake and more resources redirected towards quality efforts.

See a map of Indiana and the location of its statewide ADRCs below.


Chicago
Elkhart
South Bend
Gary
Kankakee
Fort Wayne
Kokomo
Lafayette
Indiana
Danville
Indianapolis
Richmond
Avon
Greenwood
Terre Haute
Bloomington
Columbus
Washington
Mt Carmel
Jasper
Jeffersontown
Frankfort
Tell City
Henderson
Owensboro

1. Northwest Indiana Community Action Corp. 5240 Fountain Drive Crown Point IN 46307 (800) 826-7871 http://www.nwi-ca.com/	**6. LifeStream Services, Inc.** 1701 Pilgrim Blvd. PO Box 308 Yorktown IN 47396 (800) 589-1121 http://www.lifestreaminc.org/	**11. Temporarily relocated to Cummins Inc. Engine Plant** 500 Central Avenue Columbus, IN 47201 (866)-644-6407 http://agingandcommunityservices.org/index.asp?p=1	**16 SWIRCA** 16 W. Virginia PO Box 3938 Evansville IN 47737 (800) 253-2188 http://www.swirca.org/	**21. BDDS District Office 5** 7155 Shadeland Ave. Station #160 Indianapolis, IN 46256 (317) 845-1646
2. Aging & In-Home Services of Northeast Indiana, Inc. 2927 Lake Avenue Fort Wayne IN 46805-5415 (800) 552-3662 http://www.agingihs.org/	**7. WCIEDD, Inc.** 1718 Wabash Ave PO Box 359 Terre Haute IN 47808 (800) 489-1561 http://www.westcentralin.com/area7.	**12. LifeTime Resources, Inc.** 13091 Benedict Drive Dillsboro IN 47018 (800) 742-5001 http://www.lifetime-resources.org/	**17 BDDS District Office 1** 110 W. Ridge Rd. Gary, IN 46408 (219) 981-5313	**22. BDDS District Office 6** 201 E. Charles St., Suite 130 Muncie, IN 47305 (765) 288-6516
3. Area IV Agency on Aging 660 North 36 St PO Box 4727 Lafayette IN 47903 (800) 382-7556 http://www.areaivagency.org/	**8. CICOA Aging & In-Home Solutions** 4755 Kingsway Drive, Suite 200 Indianapolis IN 46205 (800) 432-2422 http://www.cicoa.org/	**13. Generations** 1019 N. 4th St. PO Box 314 Vincennes IN 47591 (800) 742-9002 http://www.generationsnetwork.org/	**18 BDDS District Office 2** 100 W. South St., Suite 100 South Bend, IN 46601 (574) 232-1412	**23. BDDS District Office 7** 700 E. Walnut St. Evansville, IN 47713 (812) 423-8449
4. Area 5 Agency on Aging & Community Services 1801 Smith St. Logansport IN 47947 (800) 654-9421 http://www.areafive.com/	**9. Area 9 In-Home & Community Services Agency** 520 S. 9th St., Suite 100 Richmond IN 47374 (800) 458-9345 http://www.iue.edu/area9/	**14. LifeSpan Resources, Inc.** 33 State Street, 3rd Floor PO Box 995 New Albany IN 47151 (888) 948-8330 http://www.lsr14.org/	**19. BDDS District Office 3** 219 W. Wayne St. Ft. Wayne, IN 46802 (260) 423-2571	**24. BDDS District Office 8a** 1452 Vaxter St. Clarksville, IN 47129 (812) 283-1040
5. REAL Services, Inc. 1151 S. Michigan St PO Box 1835 South Bend IN 46601 (800) 552-7928 http://www.nwi-ca.com/	**10. Area 10 Agency on Aging** 630 W. Edgewood Drive Ellettsville IN 47429 (800) 844-1010 http://www.area10agency.org/	**15. Hoosier Uplands** 521 W. Main St. Mitchell IN 47446 (800) 333-2451 http://www.hoosieruplands.org/	**20. BDDS District Office 4** 30 N. 8th St. PO Box 10217 Terre Haute, IN 47802 (812) 232-3603	**25. BDDS District Office 8b** 211 N. Chestnut St. Seymour, IN 47274 (812) 522-5859

9.1 Describe Current Case Management System

Also, please refer to the Indiana_Conflict_Free_Case_Management FINAL_09.17.2012.pdf document provided to CMS on September 18, 2012, as part of Indiana's State Specific Terms and Conditions as listed in its program award notice. *******Attached with this submission, please find a revised version of this document, Indiana_Conflict_Free_Case_Management_UPDATE_01.29.2013.***

Division of Disability and Rehabilitative Services

Case Management Services means services that enable a participant to receive a full range of appropriate services in a planned, coordinated, efficient and effective manner. Case management assists participants in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained. Case Management Services must be reflected in the Individual Support Plan (ISP) and must address needs identified in the person centered planning process.

The case management entity may not own or operate another waiver service agency, nor may the case management entity be an approved provider of any other waiver service. Currently, there are four case management companies that serve DDRS consumers: Advocacy Links, LLC; The Columbus Organization (DBA); Indiana Professional Management Group, Inc. (IPMG); and Unity of Indiana (DBA).

Once it has been determined that the applicant meets all necessary Medicaid eligibility and LOC criteria by the Division of Disability and Rehabilitative Services' (DDRS) Bureau of Developmental Disability Services (BDDS) Generalists, an individual chooses a case management company as provided via pick list by a BDDS Generalist. As soon as the individual and/or his/her guardian chooses a case management company, the case will be referred to the case management entity to begin the person centered planning process.

A transition manager from that respective case management company will be assigned and the waiver participant will be given the option of selecting a new permanent case manager. This case manager will work with the participant to complete the objective based allocation (OBA) and a plan of services (cost comparison budget (CCB)) based on his/her budget. The OBA is the method used by the State to determine the level of supports an individual needs to live in a community setting. The case manager assists the participant in selecting providers and obtaining CCB approval. Once approved, waiver services may begin.

Indiana maintains a conflict-free case management policy. This covers conflict of interest in terms of provision of services as well as in relationship to the participant being served. Conflict-free means:

- The case management entity may not be an approved provider of any other waiver service.
- There may be no financial relationship between the referring Case Management entity and the provider of other waiver services.
- In addition, case managers must not be:
    - related by blood or marriage to the participant,
    - related by blood or marriage to any paid caregiver of the participant,
    - financially responsible for the participant, or
    - authorized to make financial or health-related decisions on behalf of the participant.

Division of Aging

All applicants for the Aged and Disabled (A&D) or Traumatic Brain Injury (TBI) Waivers are evaluated to assure that level of care (LOC) is met prior to receiving services. Waiver participants must meet the

minimal LOC requirements for that of a nursing facility. All initial evaluations are completed by the Area Agency on Aging (AAA) case manager and determinations are rendered by the case manager supervisor.

Indiana has established the Eligibility Screen, a tool that is used to determine basic level of care criteria that identifies nursing facility level of care. LOC evaluations are structured and monitored to assure that decisions are appropriately rendered. The waiver database contains certain edits and audits that prevent submission of an initial plan of care until all LOC requirements are met. The Waiver Operations Unit of the Division of Aging investigates and resolves plan of care and level of care issues prior to making final decision.

Case Management through the A&D and TBI Waivers may be provided by AAAs or non-AAA case management providers. If the case manager is employed by the AAA the AAA supervisor may render the LOC decision. If the case manager is not employed by a AAA, the LOC decision is rendered by the Division of Aging. All initial LOC decisions are reviewed by the Division of Aging prior to the initiation of waiver services. Case Managers do not issue any plan of care decisions as these are issued by the Division of Aging.

All potential participants for Money Follows the Person (MFP) must meet nursing facility level of care and receive a medical and functional assessment by the MFP transition specialist and transition nurse. The transition specialist and transition nurse is the point of entry into the MFP program. The same LOC determination process is completed for individuals applying for A/D waiver services (even if an individual has a developmental disability or mental illness diagnosis) as for a nursing facility.

There are specific qualifications for the MFP transition specialist and transition nurse, who have received training for LOC determination from the state. Any questionable LOC decision is sent to the Division of Aging, and all plans of care for MP participants are approved by the Division of Aging.

For individuals coming out of nursing facilities, case management is performed by the transition contractor for 365 days. Approximately 90 days before the end of the participation period, the AAA located in the county of residence is notified the individual is about to proceed to the appropriate waiver. The AAA will determine if the individual meets level of care as well as other activities, in the same manner as described above. If an individual meets level of care for waiver, he/she can choose a case manager from the AAA or from a non-AAA company, and the same case management policies that apply for A&D or TBI Waivers exist in these cases.

The Division will review case management practices within its work plan and remediate any conflicts after further analysis.

Division of Mental Health and Addiction

Community Mental Health Centers (CMHCs) both employ the case managers that perform functional assessments to determine service needs and also deliver direct behavioral health services to most DMHA consumers. On occasion, mental health service providers have case managers who provide case management to consumers.

Individuals being served by the Community Alternatives to Psychiatric Residential Treatment Facilities (CA-PRTFs) grant program, part of a demonstration grant, which ended on September 30, 2012, will be in a transition period until the 1915(I) is approved (these individuals will then be served by that program). These individuals will continue to receive case management from either a CMHC or his/her respective mental health service providers' case management staff.

The referral and eligibility process for the 1915(i) State plan option for adults is still under review at CMS. The proposed process will require a referring CMHC to perform a face to face assessment of a consumer using the ANSA to determine an individual's functional abilities. This assessment information, along with additional evaluation criteria, will be submitted to the State. Using the information provided, the State will make an independent assessment of the consumer's needs and determine whether they meet the standards required for receipt of habilitation services under the 1915(i) option. Once eligibility is approved, a service package will be authorized and the case manager from the CMHC will work with the consumer to develop an IICP addressing the consumer's individualized service needs. Eligibility for the 1915(i) will be assessed annually.

DMHA recognizes that this process does not conform to the BIP conflict of interest structural requirements, and is committed to reviewing and redesigning the processes to mitigate the conflict by the end of the BIP term in 2015. This will be done in collaboration with the Office of Medicaid Policy and Planning and other stakeholders to ensure that the system redesign not only meets the BIP standards, but also protects the best interests of consumers.

11.1. Identify Funding Sources to Implement the Structural Changes

CMS has approved an Advanced Planning Document that was submitted by Indiana to utilize Federal Financial Participation (FFP) for the design, development, and installation or enhancement of eligibility determination systems. Further, commitment from ADRCs will provide for a more robust single entry point through the co-location of state workers that perform necessary eligibility determination functions.

To provide housing opportunities for individuals transitioning into the community, the Division of Aging is working in partnership with the Indiana Housing and Community Development Authority (IHCDA). Funding will be utilized through Home Again program, which incentives to housing developers to build new units for MFP participants who are transitioning back into the community.

Further, the Real Choice Systems Change Grant, Building Sustainable Partnerships for Housing, a planning grant, will assist FSSA and IHCDA in creating and expanding Indiana's housing infrastructure for adults with mental illness. The grant will be used to further current efforts to expand the State's Permanent Supportive Housing program, which has demonstrated that individuals with chronic and serious mental illness can live successfully in apartments of their own when provided with comprehensive community support services.

11.3. Describe the Planned Usage for the Enhanced Funding

The majority of the required structural changes within the BIP will be met under the planning and implementation of a new information data system. Though the State has experienced a change in the vendor for this project, thus, and slight change in timing, efforts are still being made to ensure this system is created. Specifically, structural changes incorporated into the design and implementation of this system include creating a web-based database (which will capture and store Level I screens completed by prospective applicants), as well as Level II functional assessments (completed by agency staff as part of the LTSS application process). The new system will house some assessment data that will represent the Core Data Set necessary to meet the BIP requirement for a CSA. Finally, the new system will be available to the SEPs and other program partners in real time to support the No Wrong Door structure. Further, it will ensure that regardless of where or how an individual presents to the system, he/she will receive the same Medicaid information and be able to make application for services.
The state of Indiana also intends to utilize enhanced funding through the Balancing Incentives Program for the following purposes:

- Enrolling individuals from DDRS Medicaid waiver waitlist to be served through the Family Supports waiver.
- Investing in small group ICF/ID providers to convert their group homes into Medicaid waiver homes, which will serve approximately 1,000 individuals through the Community Integration and Habilitation Waiver beginning December 2012. *DDRS will partner with providers to create Risk Mitigation Grants to alleviate the financial burden of conversion from group home to waiver home on providers. For example: a Risk Mitigation Grant would cover the expenses that a provider incurs for training staff for new services being offered through the Waiver, ensuring better quality services are provided to consumers – thus helping them lead more independent lives in their homes, workplaces and communities.*
- Transitioning approximately 500 current nursing facility residents, who are considered to be appropriate for community-based services, into LTSS through the Developmental Disabilities waiver during FFY 2013 through FFY 2015.
- Development of Program of All-Inclusive Care for the Elderly, with at least two organizations opening centers over the next eighteen months to two years.

- Continued success in serving individuals in the Money Follows the Person Demonstration. MFP funding will continue to be utilized to transition individuals from nursing facilities or hospitals into the community. There will be no duplication of effort through BIP funds, which will only be utilized in support of this program as supplemental funding.
- Growth in home health utilization, primarily by populations served in the Aged and Disabled waiver and the Traumatic Brain Injury waiver.
- 1915(i) state plan option for adults with serious mental illness requiring habilitation services to remain in the community.

Indiana's Balancing Incentives Program: Estimated Budget

FSSA Division	Proposed Use of Enhanced FMAP	Estimated BIP Funds	Federal Financial Participation (FFP) Funds	Estimated MFP (Division of Aging)	Estimated Home Again Funds (Division of Aging & Indiana Housing and Community Development Authority)	Estimated Real Choice Funds (Division of Mental Health and Addiction & Indiana Housing and Community Development Authority)	Total
All	Information Data System (previously ICMS - automated NWD/SEP System)	$ 3,514,750.00	$ 35,147,500.00	$ -	$ -	$ -	$ 38,662,250.00
	- Level I Core assessment creation	*included in Information Data System*	$ -	$ -	$ -	$ -	$ -
	-Data reporting requirements (changes to Level II assessments to include Core Data Set domains)	*included in Information Data System*	$ -	$ -	$ -	$ -	$ -
	- Conflict-free Case Management	*included in Information Data System*	$ -	$ -	$ -	$ -	$ -
DDRS	Enroll individuals from DDRS Medicaid Waiver Waitlist to be served through the Family Supports Waiver (FSW)	$ 1,000,000.00	$ -	$ -	$ -	$ -	$ 1,000,000.00
	Convert Support Group Living (SGL) homes into Medicaid Waiver homes, transitioning residents into LTSS through the Community Integration & Habilitation (CIH) Waiver (approx. 1,000 individuals)	$ 30,000,000.00	$ -	$ -	$ -	$ -	$ 30,000,000.00
	Transition individuals from nursing facilities into LTSS through the Community Integration & Habilitation (CIH) Waiver (approx. 500 individuals)	$ 1,000,000.00	$ -	$ -	$ -	$ -	$ 1,000,000.00
DA	Develop a program off All-Inclusive Care for the Elderly (at least two organizations opening centers over the next 18-24 months)	$ 20,250,000.00	$ -	$ -	$ -	$ -	$ 20,250,000.00
	MFP Initiatives	$ -	$ -	$ 3,610,271.00	$ 300,000.00	$ -	$ 3,910,271.00
DMHA	Increase home health and 1951(i) State Plan Option	15,000,000.00	-	-	-	330,000.00	$ 15,330,000.00
	Promote recovery and reduce risk of readmission into state operated facilities for individuals with SMI or SMI/CA who transition into LTSS	7,235,250.00	-	-			7,235,250.00
		$ 78,000,000.00	$ 35,147,500.00	$ 3,610,271.00	$ 300,000.00	$ 330,000.00	**$ 117,387,771.00**

NOTES:
* These amounts and totals are only considered estimates at this time. Indiana is uncertain as to how much the Information System will cost, as it is still working on identifying how it will move forward in this process. The estimates for the Information Data System are based on estimates provided by the previous vendor's bid to complete the ICMS system. However, the scope for this project will likely be different than what was drafted for the ICMS bid, which may significantly reduce the estimated cost. Updates to this information will occur on a regular reporting basis. Dependent upon final estimates for a new system bid, these numbers may fluctuate, and funding through both BIP and FFP funds may be utilized.

Further, DDRS is still processing grant applications from Group Home providers to convert their homes to Waiver homes, and the end result in monies allocated is still unforeseen.

Home Again funds and Real Choice funds will be utilized to assist in housing for individuals through the Money Follows the Person program, as well as those with mental illness, respectively. The State is still working with its Housing and Community Development Authority on specifics regarding funds.

Updates to this budget will occur on a regular reporting basis.

Addendum: Division of Mental Health and Addiction

State Operated Facilities Alternatives Supports Proposal

The Division of Mental Health and Addiction (DMHA), through the Balancing Incentives Program (BIP), would like to propose a method by which it would utilize BIP funding to help support individuals who transition into the community from state operated facilities or other institutional settings.

Background

As of July 1, 2012, DMHA has redirected its distribution of carve-out funding for Assertive Community Treatment (ACT), State Operated Facility (SOF) agreements, and its Bed Buy Back program for an alternative funding distribution methodology that meets the needs of individuals with serious mental illness or co-occurring (SMI/CA) disorders who are at risk of, or are currently, residing in a state hospital. This alternative methodology includes funding and support for start –up costs as described in requests for proposals from Community Mental Health Centers (CMHCs) for Local, County, Regional or Statewide Alternatives to State Hospitalization for individuals with SMI and Co-Occurring (SMI/CA) Disorders. These projects may include development of programs to implement recovery supports (e.g., housing, employment, medical, engagement and outreach, etc.)

Projects are to implement evidence-based and/or promising practices for services and supports to promote recovery and reduce risk for state hospitalization for the following individuals:

- Consumers residing in State Operated Facilities who have been identified as able to live in the community but for whom no/limited appropriate community placement exists;
- Consumers currently residing in State Operated Facilities who have medical needs but do not meet Level of Care for a Nursing Facility;
- Consumers currently residing in State Operated Facilities with a diagnosis for which the incidence and prevalence is so small that they could be served most efficiently regionally or statewide rather than on a local basis;
- Proposals targeting other groups of consumers will be considered if they are able to meet the goals of reducing hospitalization and increasing consumer independence using a recovery focused model of care.

Project proposals that are funded through this redirection of funds are being evaluated on a quarterly basis with specific quality measures respective of each CMHC's project. However, all projects proposals were initially evaluated for funding based upon the following criteria:

1. The potential of the proposed initiative to move individuals currently in a State Operated Facility into successful community-based services;
2. The potential of the proposed initiative to successfully move individuals with SMI and Co-occurring disorders into less restrictive community-based alternatives;
3. The potential of the proposed initiative to reduce the number of individuals currently identified as ready for community placement;
4. Feasibility of accomplishing measurable objectives within time frame;
5. Degree to which proposals support concepts of recovery oriented, non-institutional, consumer- empowered, culturally-sensitive, community-based interventions and support;
6. Documented level of community support including fiscal support;
7. Plan for sustainability beyond DMHA funding contract period;
8. Supporting documentation of partners and their roles including but not limited to participation and cooperation of other systems that impact the success of consumers (e.g. housing, workforce development, community health programs);
9. The cost of the program. Factors as the size of the area to be served, the number of consumers to be served, and the type of consumers to be served, will be taken into consideration when evaluating the cost of the program.

BIP Funds

Via its share of BIP funding, the Division of Mental Health and Addictions proposes to continue to support individuals with SMI or SMI/CA disorders who transition through these projects. To promote recovery and reduce the risk of readmission into state hospitals, DMHA proposes to utilize BIP funding to ensure programs, resources, and other supports exist within the community, such as:

- Programs designed to provide intensive wraparound service supports, such as peer support, counseling, employment, nursing/medical services, among others, for individuals who are reintegrated into the community after having been in a state operated facility for at least 12 months. These programs coexist with local Housing Authority community integration programs, which assist with finding housing for this population.
- Programs that are designed to support the medically fragile within the community setting.
- Programs designed specifically to support individuals returning to the community after extended and or repeated stays at the State Operated Facility. The target population is individuals who would need more than traditional supportive services to sustain recovery in the community.

Total budget for current funded projects for SFY 2013: $7,235,250

Sustainability Plan for continued funding

The Division of Mental Health and Addiction has allocated funds each fiscal year as designated for individuals who are long term state hospital patients and are eligible for transition into the community, as well as for individuals in the community who are at imminent risk of hospitalization. Last State Fiscal year, the Division of Mental Health and Addiction made the decision to revise the way funds were being allocated. The project described above enables requests for proposals to be offered to the Community Mental Health Centers to deinstitutionalize and/or retain community placements for this population. DMHA will continue to support and fund these programs over the next two fiscal year cycles commensurate with performance-based criteria by which the CMHCs must be measured.